FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0019471

Facility Name: The Arbor

Address: 535 South Elm St. (Number) Itasca (City) 60143 (Zip Code)

County: DuPage

Telephone Number: (630) 773-9416 **Fax #** (630) 773-9434

IDPA ID Number: 362848501001

Date of Initial License for Current Owners: 08/06/1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-4580
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/04 to 12/31/04 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3	68	Intermediate (ICF)	68	24,888	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	144	TOTALS	144	52,704	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			2,242	2,242	8
9	SNF/PED					9
10	ICF	31,404	8,773		40,177	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,404	8,773	2,242	42,419	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.49%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/06/1975

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 2,210

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/04 Fiscal Year: 12/31/04

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	229,605	31,036	7,892	268,533		268,533		268,533			1
2	Food Purchase		219,642		219,642		219,642		219,642			2
3	Housekeeping		16,501	221,529	238,030		238,030		238,030			3
4	Laundry		5,527		5,527		5,527		5,527			4
5	Heat and Other Utilities			89,711	89,711		89,711		89,711			5
6	Maintenance		5,230	41,051	46,281		46,281		46,281			6
7	Other (specify):*											7
8	**TOTAL General Services**	229,605	277,936	360,183	867,724		867,724		867,724			8
	B. Health Care and Programs											
9	Medical Director			5,400	5,400		5,400		5,400			9
10	Nursing and Medical Records	1,896,006	133,451	114,954	2,144,411		2,144,411		2,144,411			10
10a	Therapy			178,487	178,487		178,487		178,487			10a
11	Activities	91,109	3,600	1,248	95,957		95,957		95,957			11
12	Social Services	40,972		1,980	42,952		42,952		42,952			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,028,087	137,051	302,069	2,467,207		2,467,207		2,467,207			16
	C. General Administration											
17	Administrative	161,638			161,638		161,638		161,638			17
18	Directors Fees			30,000	30,000		30,000		30,000			18
19	Professional Services			93,518	93,518		93,518		93,518			19
20	Dues, Fees, Subscriptions & Promotions			16,080	16,080		16,080	(891)	15,189			20
21	Clerical & General Office Expenses	115,762	26,491	21,650	163,903		163,903	(2,508)	161,395			21
22	Employee Benefits & Payroll Taxes			355,586	355,586		355,586		355,586			22
23	Inservice Training & Education			160	160		160		160			23
24	Travel and Seminar											24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			106,511	106,511		106,511		106,511			26
27	Other (specify):*											27
28	**TOTAL General Administration**	277,400	26,491	623,505	927,396		927,396	(3,399)	923,997			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,535,092	441,478	1,285,757	4,262,327		4,262,327	(3,399)	4,258,928			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number The Arbor #0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			12,682	12,682		12,682	103,316	115,998			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,808	19,808		19,808	400,251	420,059			32
33	Real Estate Taxes							53,934	53,934			33
34	Rent-Facility & Grounds			445,840	445,840		445,840	(445,840)				34
35	Rent-Equipment & Vehicles			7,944	7,944		7,944		7,944			35
36	Other (specify):* MIP Insurance							26,425	26,425			36
37	**TOTAL Ownership**			486,274	486,274		486,274	138,086	624,360			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		84,522		84,522		84,522		84,522			39
40	Barber and Beauty Shops			3,576	3,576		3,576		3,576			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			79,056	79,056		79,056		79,056			42
43	Other (specify):* Nonallowable Costs			24,255	24,255		24,255	(24,255)				43
44	**TOTAL Special Cost Centers**		84,522	106,887	191,409		191,409	(24,255)	167,154			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,535,092	526,000	1,878,918	4,940,010		4,940,010	110,432	5,050,442			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(5,590)	30		9
10	Interest and Other Investment Income	(928)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(776)	43		13
14	Non-Care Related Interest	(11,500)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,446)	43		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,918)	43		24
25	Fund Raising, Advertising and Promotional	(12,570)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Attachment 5A	(13,740)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (51,468)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	161,900		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 161,900		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 110,432		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor
Provider #: 0019471
01/01/04 to 12/31/04

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

Non-allowable expenses	Amount	Reference
To disallow PAC contributions	(691)	20
To disallow part A lab expense	(2,587)	43
Offset miscellaneous income	(2,508)	21
To disallow vending machine expense	(3,768)	43
To disallow non-allowable dues	(200)	20
To disallow X-Ray - Part A	1,810	43
To disallow State Replacement Tax	(6,447)	43
To disallow Franchise Tax	(250)	43
Related organization's miscellaneous income	901	n/a
TOTAL	($13,740)	

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor

ID# 0019471

Report Period Beginning: 01/01/04

Ending: 12/31/04

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number The Arbor # 0019471 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	0	0	0	0	0	0	0	0	0	0	0	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number The Arbor # 0019471 **Report Period Beginning:** 01/01/04 **Ending:** 12/31/04

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(5,590)	#REF!	0	0	0	0	0	0	0	0	0	#REF!	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(12,428)	(901)	0	0	0	0	0	0	0	0	0	(13,329)	32
33	Real Estate Taxes	0	108,906	0	0	0	0	0	0	0	0	0	108,906	33
34	Rent-Facility & Grounds	0	(445,840)	0	0	0	0	0	0	0	0	0	(445,840)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	53,934	0	0	0	0	0	0	0	0	0	53,934	36
37	**TOTAL Ownership**	(18,018)	#REF!	0	0	0	0	0	0	0	0	0	#REF!	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(19,710)	#REF!	0	0	0	0	0	0	0	0	0	#REF!	43
44	**TOTAL Special Cost Centers**	(19,710)	#REF!	0	0	0	0	0	0	0	0	0	#REF!	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(37,728)	#REF!	0	0	0	0	0	0	0	0	0	#REF!	45

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
John Florina, Sr.	30.00%			Itasca Shelter Care, L.L.C.	Itasca	Lessor
John Florina, Jr.	10.00%					
Duane Jacobson	30.00%					
Charles Ricci	30.00%					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	30	Depreciation	$	Itasca Shelter Care, L.L.C.	100.00%	$ 108,906	$ 108,906	1
2	V	32	Interest		Itasca Shelter Care, L.L.C.	100.00%	412,679	412,679	2
3	V	33	Real estate taxes		Itasca Shelter Care, L.L.C.	100.00%	53,934	53,934	3
4	V	34	Rental income	445,840	Itasca Shelter Care, L.L.C.	100.00%		(445,840)	4
5	V	36	MIP Insurance		Itasca Shelter Care, L.L.C.	100.00%	26,425	26,425	5
6	V	43	State Replacement Tax		Itasca Shelter Care, L.L.C.	100.00%	6,447	6,447	6
7	V	43	Franchise Tax		Itasca Shelter Care, L.L.C.	100.00%	250	250	7
8	V	n/a	Miscellaneous income		Itasca Shelter Care, L.L.C.	100.00%	(901)	(901)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 445,840			$ 607,740	$ * 161,900	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	John Florina Jr	Admin/Asst. Admin	Administration	10.00	None	40	100.00	Salary	$ 94,123	L17, C1	1
2	Duane Jacobson	Owner	Board	30.00	None	8	20.00	Director fees	10,000	L18, C3	2
3	Charles Ricci	Owner	Board	30.00	None	8	20.00	Director fees	10,000	L18, C3	3
4	John Florina, Sr	Owner	Board	30.00	None	8	20.00	Director fees	10,000	L18, C3	4
5	Barbara Florina	Bookkeeper	Clerical	0.00	None	3	100.00	Wage	63	L21, C1	5
6	Daniel Florina	Contractor	Snow removal	0.00	None	Varied	Varied	Contract	938	L6, C3	6
7	Robert Florina	Contractor	Repairs & Maintar	0.00	None	Varied	Varied	Contract	3,760	L6, C3	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 128,884		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9		N/A								9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Cambridge		x	Mortgage	$36,889.00	1/31/00	$ 5,089,300	$ 4,939,580	02/01/35	0.0820	$ 406,415	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bloomingdale Bank & Trust		x	Line of credit	int. only	04/11/03	250,000	250,000	on demand	0.0500	8,357	6
7	Shareholder loans	x		Working capital	none	12/31/03	230,000	230,000	on demand	0.0500	11,500	7
8	Itasca Bank & Trust		X	Line of Credit	int. only	4/11/04	225,000	100,000	04/11/2005	0.0525	160	8
9	TOTAL Facility Related				$36,889.00		$ 5,794,300	$ 5,519,580			$ 426,432	9
	B. Non-Facility Related*											
10								Amortization of mortgage costs			6,055	10
11								Nonallowable shareholder interest			(11,500)	11
12								Interest income offset			(928)	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (6,373)	14
15	TOTALS (line 9+line14)						$ 5,794,300	$ 5,519,580			$ 420,059	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$ 26,425** **Line # 36**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.		$ 60,700	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2003	$ 57,334	2
3. Under or (over) accrual (line 2 minus line 1).		$ (3,366)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 57,300	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 53,934	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	51,569	8
	2000	53,167	9
	2001	54,297	10
	2002	57,779	11
	2003	57,334	12

2002 Taxes Paid	$57,779
2003 Taxes Paid	$57,334
% Decrease	.99%
Real Estate Taxes accrual	$57,334 use $57,300

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME The Arbor COUNTY DuPage

FACILITY IDPH LICENSE NUMBER 0019471

CONTACT PERSON REGARDING THIS REPORT John Florina, Jr.

TELEPHONE (630) 773-9416 FAX #: (630) 773-9434

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	03-17-102-040	Nursing Home	$ 1,672.60	$ 1,672.60
2.	03-17-102-041	Nursing Home	$ 27,510.94	$ 27,510.94
3.	03-17-102-045	Nursing Home	$ 28,149.96	$ 28,149.96
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,333.50	$ 57,333.50

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 200 tax bill which is normally paid during 2004

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 46,391 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Patient Care	41,000	1975	$ 9,559	1
2	Patient Care	44,336	1992	10,446	2
3	TOTALS	85,336		$ 20,005	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1975	1975	$ 271,012	$	40	$ 6,775	$ 6,775	$ 200,172	4
5			1975	1975	187,817		25			187,817	5
6			1975	1975	113,922		20			113,922	6
7			1975	1975	20,747		10			20,747	7
8	76		1993	1993	2,533,506		40	62,937	62,937	739,918	8
	Improvement Type**										
9	Building Improvements			1976	7,019		25			7,019	9
10	Building Improvements			1976	10,352		40	259	259	7,376	10
11	Building Improvements			1976	2,620		36	73	73	1,861	11
12	Building Improvements			1976	243		10			243	12
13	Building Improvements			1976	608		4			608	13
14	Building Improvements			1987	5,847		20			5,847	14
15	Building Improvements			1988	32,894		35	940	940	15,196	15
16	Building Improvements			1991	32,267		35	922	922	12,447	16
17	Building Improvements			1993	168,024		40	4,201	4,201	48,309	17
18	Building Improvements			1993	21,405		40	535	535	6,145	18
19	Building Improvements			1987	12,923	410	35	369	(41)	6,462	19
20	Building Improvements			1988	6,270	199	35	179	(20)	3,044	20
21	Building Improvements			1990	21,197	674	35	605	(69)	8,785	21
22	Building Improvements			1991	986	31	35	28	(3)	379	22
23	Building Improvements			1992	7,503	238	35	214	(24)	2,676	23
24	Building Improvements			1993	12,681	325	40	317	(8)	3,646	24
25	Building Improvements			1994	3,100	79	40	78	(1)	816	25
26	Building Improvements			1994	11,175	287	40	279	(8)	2,931	26
27	Building Improvements			1995	15,605		10	1,561	1,561	14,437	27
28	Cabinets			1996	2,768	89	31	89		757	28
29	Electrical Fixtures			1996	4,972	160	31	160		1,320	29
30	Cabinets			1996	3,097	100	31	100		808	30
31	Building Improvements			1984	12,774		10			12,774	31
32	Building Improvements			1985	7,314		10			7,314	32
33	Building Improvements			1986	4,044		8			4,044	33
34	Building Improvements			1986	1,379		8			1,379	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Front Door Security System	1997	$ 6,230	$ 201	31	$ 201	$	$ 1,507	37
38	Concrete Pads for Washers	1997	4,430	143	31	143		1,060	38
39	Carpeting	1997	7,271	235	31	235		1,664	39
40	Complete Communications-Nurse Calling Systen	1998	4,543	147	31	147		919	40
41	New Door Opening	1999	1,798	58	31	58		343	41
42	Window Replacement	2000	4,801	155	31	155		633	42
43	Roof	2001	3,665	118	31	118		433	43
44	Hot Water Heater	2001	2,891	93	31	93		333	44
45	Hot Water Heater	2002	885	29	31	29		84	45
46	Landscape Improvements (sidewalks/walkways)	2002	925	29	31	29		70	46
47	Driveway	2004	2,432	39	31	33	(6)	33	47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,575,942	$ 3,839		$ 81,862	$ 78,023	$ 1,446,278	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 455,959	$ 7,956	$ 24,400	$ 16,444	5-10 years	$ 407,084	71
72	Current Year Purchases	5,475	887	492	(395)	5-10 years	492	72
73	Fully Depreciated Assets	175,987				5-10 years	175,987	73
74								74
75	TOTALS	$ 637,421	$ 8,843	$ 24,892	$ 16,049		$ 583,563	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	2001 Chevrolet Bus	2001	$ 46,219	$	$ 9,244	$ 9,244	5	$ 32,354	76
77										77
78										78
79										79
80	TOTALS			$ 46,219	$	$ 9,244	$ 9,244		$ 32,354	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,279,587	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 12,682	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 115,998	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 103,316	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,062,195	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Itasca Shelter Care L.L.C. - See page 6

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ X NO

16. Rental Amount for movable equipment: $ None Description: N/A
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Administrative	2002 Suburban	$ 662.04	$ 7,944	17
18					18
19					19
20					20
21	TOTAL		$ 662.04	$ 7,944	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	5,336	$	79,253	$	5,336	$ 79,253	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		386		5,855		386	5,855	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist	L10A, C3	hrs		6,329		93,379		6,329	93,379	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy	L39, C2	# of prescrpts					84,522		84,522	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	12,051	$	178,487	$ 84,522	12,051	$ 263,009	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

The Arbor
Provider #: 0019471
01/01/04 to 12/31/04 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 21,003	$ 80,274	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 65,000)	1,351,633	1,351,633	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	69,393	69,393	6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Escrow & Replacement Res.		258,400	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,442,029	$ 1,759,700	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		20,005	13
14	Buildings, at Historical Cost		3,039,771	14
15	Leasehold Improvements, at Historical Cost	127,233	536,171	15
16	Equipment, at Historical Cost	349,916	683,640	16
17	Accumulated Depreciation (book methods)	(358,617)	(2,062,195)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Mtg. Costs		182,154	22
23	Other(specify): Deferred Costs-Apts.		1,272	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 118,532	$ 2,400,818	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,560,561	$ 4,160,518	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 336,926	$ 336,926	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	13,250	13,250	28
29	Short-Term Notes Payable	580,000	580,000	29
30	Accrued Salaries Payable	42,095	42,095	30
31	Accrued Taxes Payable (excluding real estate taxes)	1,738	1,738	31
32	Accrued Real Estate Taxes(Sch.IX-B)		57,300	32
33	Accrued Interest Payable	23,275	57,025	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 997,284	$ 1,088,334	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		4,939,580	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 4,939,580	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 997,284	$ 6,027,914	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 563,277	$ (1,867,396)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,560,561	$ 4,160,518	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

The Arbor of Itasca, Inc.
Provider #0019471
12/31/2004

Schedule 17A

XV. Balance Sheet
Line 9 - Other Assets

	Operating	After Consolidation
Current Assets		
Escrow and Replacement Reserves	-	-
	-	-

See Accountants' Compilation Report

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 291,761	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 291,761	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	271,516	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 271,516	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 563,277	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,047,727	1
2	Discounts and Allowances for all Levels	(336,523)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,711,204	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	355,143	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 355,143	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	6,021	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	81,383	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	42,287	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 129,691	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	27	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 27	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Miscellaneous Income	9,898	28
28a	Vending Machine Income	5,563	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 15,461	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,211,526	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	867,724	31
32	Health Care	2,467,207	32
33	General Administration	927,396	33
	B. Capital Expense		
34	Ownership	486,274	34
	C. Ancillary Expense		
35	Special Cost Centers	112,353	35
36	Provider Participation Fee	79,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,940,010	40
41	**Income before Income Taxes (line 30 minus line 40)****	271,516	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 271,516	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,231	2,304	$ 67,178	$ 29.16	1
2	Assistant Director of Nursing	2,163	2,105	58,225	27.66	2
3	Registered Nurses	18,023	18,071	457,834	25.34	3
4	Licensed Practical Nurses	10,604	10,669	258,183	24.20	4
5	Nurse Aides & Orderlies	79,982	80,190	1,004,648	12.53	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,396	2,128	30,370	14.27	9
10	Activity Assistants	7,042	7,123	60,739	8.53	10
11	Social Service Workers	2,171	2,260	40,972	18.13	11
12	Dietician					12
13	Food Service Supervisor	2,506	2,160	38,268	17.72	13
14	Head Cook	6,687	6,695	76,535	11.43	14
15	Cook Helpers/Assistants	15,145	15,167	114,802	7.57	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,358	2,160	67,515	31.26	20
21	Assistant Administrator	2,367	2,160	94,123	43.58	21
22	Other Administrative	2,106	2,112	40,054	18.96	22
23	Office Manager					23
24	Clerical	4,947	5,066	75,708	14.94	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca RCC	2,293	2,260	49,938	22.10	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	163,021	162,630	$ 2,535,092 *	$ 15.59	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	190	$ 7,892	L1, C3	35
36	Medical Director	125	5,400	L9, C3	36
37	Medical Records Consultant	18	1,018	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	100	1,410	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	24	1,248	L11, C3	44
45	Social Service Consultant	36	1,980	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	493	$ 18,948		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	172	$ 9,039	L10, C3	50
51	Licensed Practical Nurses	2,692	103,295	L10, C3	51
52	Nurse Aides	8	192	L10, C3	52
53	TOTAL (lines 50 - 52)	2,872	$ 112,526		53

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
John Florina Jr	Admin/Asst. Admin	10.00	$ 94,123
Thomas Annarella	Administrator	0	67,515
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 161,638

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
American Express Tax &		$
Business Services	Accounting	8,045
Achieve Software	Computer services	6,553
Altschuler Melvoin & Glasser	Accounting	50,555
Porte Brown LLC	U/C Consulting	3,575
Personnel Planners	U/C Consulting	636
Stratton, Giganti, Stone & Kopec	Legal	1,219
Accurate Computer Services	Computer services	1,697
Ivans	Computer services	497
Arch Alliance	Computer services	20,741
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 93,518

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 79,636
Unemployment Compensation Insurance	14,314
FICA Taxes	190,364
Employee Health Insurance	59,841
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	11,431
TOTAL (agree to Schedule V, line 22, col.8)	$ 355,586

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	4,221
Health Care Worker Background Check	400
(Indicate # of checks performed 35)	
Illinois Health Care Association Dues	7,776
Miscellaneous Subscriptions	486
Miscellaneous Dues	615
Miscellaneous Licenses	1,543
Miscellaneous Inspections	148
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,189

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

The Arbor
Provider #: 0019471
01/01/04 to 12/31/04 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	$93,518
Allocated from Management Company	$0
Total (agree to Schedule V, line 19, column 8)	$93,518

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9	N/A												
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number The Arbor # 0019471 Report Period Beginning: 01/01/04 Ending: 12/31/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $7776**

(3) Did the nursing home make political contributions or payments to a politica action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **68,763** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **79,056**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	229,605	31,036	7,892	268,533	0	268,533	0	268,533
2. Food Purchase	0	219,642	0	219,642	0	219,642	0	219,642
3. Housekeeping	0	16,501	221,529	238,030	0	238,030	0	238,030
4. Laundry	0	5,527	0	5,527	0	5,527	0	5,527
5. Heat and Other Utilities	0	0	89,711	89,711	0	89,711	0	89,711
6. Maintenance	0	5,230	41,051	46,281	0	46,281	0	46,281
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	229,605	277,936	360,183	867,724	0	867,724	0	867,724
9. Medical Director	0	0	5,400	5,400	0	5,400	0	5,400
10. Nursing & Medical Records	1,896,006	133,451	114,954	2,144,411	0	2,144,411	0	2,144,411
10a. Therapy	0	0	178,487	178,487	0	178,487	0	178,487
11. Activities	91,109	3,600	1,248	95,957	0	95,957	0	95,957
12. Social Services	40,972	0	1,980	42,952	0	42,952	0	42,952
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	2,028,087	137,051	302,069	2,467,207	0	2,467,207	0	2,467,207
17. Administrative	161,638	0	0	161,638	0	161,638	0	161,638
18. Directors Fees	0	0	30,000	30,000	0	30,000	0	30,000
19. Professional Services	0	0	93,518	93,518	0	93,518	0	93,518
20. Fees, Subscriptions & Promotion	0	0	16,080	16,080	0	16,080	-891	15,189
21. Clerical & General Office	115,762	26,491	21,650	163,903	0	163,903	-2,508	161,395
22. Employee Benefits & Payroll	0	0	355,586	355,586	0	355,586	0	355,586
23. Inservice Training & Education	0	0	160	160	0	160	0	160
24. Travel and Seminar	0	0	0	0	0	0	0	0
25. Other Admin. Staff Trans	0	0	0	0	0	0	0	0
26. Insurance-Prop.Liab.Malpractice	0	0	106,511	106,511	0	106,511	0	106,511
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	277,400	26,491	623,505	927,396	0	927,396	-3,399	923,997
29. Total General Administrative	2,535,092	441,478	1,285,757	4,262,327	0	4,262,327	-3,399	4,258,928
30. Depreciation	0	0	12,682	12,682	0	12,682	103,316	115,998
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	19,808	19,808	0	19,808	400,251	420,059
33. Real Estate	0	0	0	0	0	0	53,934	53,934
34. Rent - Facility & Grounds	0	0	445,840	445,840	0	445,840	-445,840	0
35. Rent - Equipment & Vehicles	0	0	7,944	7,944	0	7,944	0	7,944
36. Other (specify):*	0	0	0	0	0	0	26,425	26,425
37. Total Ownership	0	0	486,274	486,274	0	486,274	138,086	624,360
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	84,522	0	84,522	0	84,522	0	84,522
40. Barber and Beauty Shop	0	0	3,576	3,576	0	3,576	0	3,576
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	79,056	79,056	0	79,056	0	79,056
43. Other (specify):*	0	0	24,255	24,255	0	24,255	-24,255	0
44. Total Special Cost Ce	0	84,522	106,887	191,409	0	191,409	-24,255	167,154
45. Grand Total	2,535,092	526,000	1,878,918	4,940,010	0	4,940,010	110,432	5,050,442

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	21,003	80,274
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	1,351,633	1,351,633
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	69,393	69,393
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	258,400
10. Total current assets	1,442,029	1,759,700
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	20,005
14. Buildings, at Historical Cost	0	3,039,771
15. Leasehold Improvements, Historical Cost	127,233	536,171
16. Equipment, at Historical Cost	349,916	683,640
17. Accumulated Depreciation (book methods)	-358,617	-2,062,195
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	182,154
23. other (specify):	0	1,272
24. Total Long-Term Assets	118,532	2,400,818
25. Total Assets	1,560,561	4,160,518
CURRENT LIABILITIES		
26. Accounts Payable	336,926	336,926
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	13,250	13,250
29. Short-Term Notes Payable	580,000	580,000
30. Accrued Salaries Payable	42,095	42,095
31. Accrued Taxes Payable	1,738	1,738
32. Accrued Real Estate Taxes	0	57,300
33. Accrued Interest Payable	23,275	57,025
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	0	0
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	997,284	1,088,334
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	4,939,580
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	4,939,580
46.Total Liabilities	997,284	6,027,914
47.Total Equity	401,378	-1,867,396
48.Total Liabilities and Equity	1,398,662	4,160,518

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,047,727
2. Discounts and Allowances for all Levels	-336,523
Subtotal - Inpatient Care	4,716,171
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	355,143
7. Oxygen	0
Subtotal - Anciliary Revenue	355,143
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	6,021
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	81,383
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	42,287
22. Laundry	0
Subtotal - Other Operating Revenue	129,691
24. Contributions	0
25. Interest and Other Investments Income	27
Subtotal - Non-Operating Revenue	27
27. Other Revenue (specify):	9,898
28. Other Revenue (specify):	5,563
Subtotal - Other Revenue	15,461
30. Total Revenue	5,216,493
31. General Services	867,724
32. Health Care	2,467,207
33. General Administration	927,396
34. Ownership	486,274
35. Special Cost Centers	112,353
35. Provider Participation Fee	79,056
37. Other	0
40. Total Expenses	4,940,010
41. Income Before Income Taxes	276,483
42. Income Taxes	0
43. Net Income or Loss for the Year	276,483

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